The California Managed Risk Medical Insurance Board
PO Box 2769
Sacramento, CA 95812-2769
Phone: (916) 324-4695
Fax: (916) 324-4878

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Managed Risk Medical Insurance Board
HFP Advisory Panel Meeting Summary
May 11, 2010
West Sacramento, California

Attendees: Jack Campana, Maria Tupas, Takashi Wada, Elizabeth Stanley Salazar, Anastasia Gaspay, Irma Hernandez, Karen Lauterbach, Martin Steigner, and Steven Tremain.

MRMIB Staff: Lesley Cummings, Thien Lam, Theresa Gomez, Ernesto Sanchez, Shelley Rouillard, Deborah Blatt, and Adriana Valdez

Introductions

Jack Campana, Healthy Families Program (HFP) Advisory Panel Chairperson, opened the meeting by introducing himself and asking the Panel members, Managed Risk Medical Insurance Board (MRMIB) staff, and the audience to introduce themselves.

Doctor Maria Tupas is a new addition to the panel and was sworn in by Ernesto Sanchez.

Review and Approval of the February 9, 2010 meeting

The HFP Advisory Panel accepted and approved the February 9, 2010 meeting summary.

HFP Advisory Panel New Member Oath & Vacancies

Ernesto Sanchez, Deputy Director of Eligibility, Enrollment & Marketing Division, made an announcement about four vacancies on the Advisory Panel. The HFP Advisory Panel is searching for members for a subscriber representative, a representative from the family practices physicians, for the disproportionate share hospital representative, and for the county health representative. Resumes will be accepted from interested candidates through June 1, 2010. Existing members need only inform Mr. Sanchez if they are interested in staying on the panel. More information about the vacancies is available on the MRMIB website.

Federal Budget, Legislation, and Executive Branch Activity (Including Healthcare Reform, Economic Stimulus & Budget)

Mr. Sanchez first presented Agenda Item 4 C, and acknowledged that the New Federal Health Care reform bill has been signed and put into law by President Obama, on March 23, 2010.

This agenda item is in regards to a new federal temporary high-risk pool. There is a letter from Secretary Sebelius to the Governor that outlines a temporary federal high-

risk pool, and asks the Governor to express interest in administrating a temporary high-risk pool. The risk pool would be in addition to the current state high-risk pool and it would operate beside it.

The new requirements to be eligible for the federal high risk pool would be for individuals who are citizens, nationals, or lawfully present individuals in the United States that cannot have coverage in last 6 months before applying for coverage and have a pre-existing condition as determined in a manner consistent with guidance issued by the secretary of health and human services. Available coverage is 65% of total cost of a benefit package (that has not yet been defined by the federal government). Cost share limits are approximately $ 5,950 for an individual and twice that much for a family. An Individual cannot subject to any pre-existing condition exclusions. The premiums will be at a 100% of the market rate and they will allow for age rating of no more than 4 to 1 (See page 2 of the handout marked Agenda Item 4.c for some of the rules and options that the state can consider).

On April 30, 2010, California submitted a letter of interest to the federal government to administer this program. MRMIB may potentially be administering the new federal high-risk pool but there are still a lot of details to be worked out. On the MRMIB website, there is a comparison of the existing state high-risk pool and the new temporary high-risk pool product. The eligibility requirements are not all consistent.

For more information about this report, please follow the link here:
http://www.mrmib.ca.gov/MRMIB/agenda042110.htmlFederal Interim High Risk Pool

d. CHIP

There is a summary of changes of the federal health reform law in Medicaid, CHIP, and low income. The handout talks about the creation of current exchanges which will start in January 2014. It provides Medicaid eligibility for childless adults up to 133% of the poverty level. In the exchange, it also talks about the ability to provide tax credits for individuals whose income is at 400% or below the federal poverty level. The new mandatory adjusted gross income, which is something MRMIB will be working on with the Department of Health Care Services, is standard. It defines a new insurance exchange for individuals and small groups with employees. States must define small groups as 100 or less employees; but the state can define it as 1 to 50 employees. The market reform that this package includes is eliminating the practice of denying people's coverage because they are sick and being charged different premiums based on their health status.

On the second page of the handout, Medicaid & CHIP are raising the Federal Poverty Level (FPL) up to 133% for this new group of individuals that the federal government they will pay 100% of costs from 2014 to 2016. The Maintenance of Efforts (MOE) requirement is a big issue for all states under this provision for both CHIP and for Medicaid. They are not allowed to change eligibility levels, mechanisms, and procedures from what they were from March 23, 2010, when the bill was signed into law by the president. There is also an option wavier for those new lawfully residing immigrants.

The handout also discusses Medicaid coverage for children up to 133%, which would mean by 2014, and could be done sooner than this. This would mean that these children would move out of the Healthy Families Program and into the Medi-Cal Program. It also discusses the new adjusted gross income standard. It extends the authorization for the CHIP program through 2019 and only funds it until 2015. It increases the CHIP federal matching rate from 65% by an addition 23%. The only problem with this is that they do not do this until the federal fiscal year of 2016, which starts in October 2015. It does provide Medicaid coverage to former foster care children who will age out of Medi-Cal until they provide an option for state employee children under the Health Families Program.

The fourth page explains the exchange and of some of the coverage as well as the screening and enrollment procedures of Medicaid and CHIP. MRMIB is going to have to coordinate with this new exchange. Streamline enrollment and uniform process and doing administrative verification for citizenship, immigrant status, and income are mentioned as well. The secretary of Health and Human Services will give access at a federal level.

Currently, the Medicaid program has given CHIP an option to verify citizenship and identify through the Social Security Administration. When they are provided the Social Security Number (SSN), the results are for a 94% match rate. Medicaid agencies and the CHIP program are going to have to know when somebody applies to the program. It looks like they are eligible for the exchange and they will have to tell them what tax credit or subsidy they would qualify for. There is going to be a lot of interconnection activity in the future and this means to us to be able to access to people tax records through the IRS to validate income eligibly.

In the insurance exchange, there is going to be four levels of coverage: the bronze, silver, gold, and platinum. It means that you have to cover the minimum benefit package designed by the federal government. It starts at a 60% actuarial value for the bronze package and goes up to 90% value for the platinum package. Some of the changes in coverage that market reform address children's coverage to last until the child turns 26. Coverage to children cannot be denied because of a pre-existing condition that was supposed to take effect in October 1, 2010. Secretary Sebelius has sent a letter out to most of the major insurers' nation wide and most of them had agreed to implement that provision early.

For more information about this report, please follow the link:
http://www.mrmib.ca.gov/MRMIB/agenda042110.htmlCHIP

e. Insurance Rates

There is a letter again from Secretary Sebelius to the insurance companies asking them to take dependence coverage up to the age of 26, which is sooner than the original September 23rd date.

Mr. Sanchez asked the panel if there are any questions to follow up.

Dr. Steven Tremain asked if children who are under age 26 and are between the ages of 23 to 26 who have already been disenrolled could get back on after September 23rd.

Mr. Sanchez stated that these children would have to be on by September 23rd. Most of these plans are going along with re-enrolling these children. Many people are concerned that the reason the September 23rd date is being pushed up is that the school year will soon end, and many kids may no longer qualify for their parents' coverage because they may be graduating soon. There is no point in dropping children from their coverage in May when they have to be enrolled in September.

Mr. Campana stated that very few people know what this health care reform means there is not enough information out there.

Ms. Elizabeth Stanley-Salazar asked if there is a plan to do something about this issue. Ms. Stanley-Salazar stated that she read a good consumer piece in AARP that was excellent, but it is tailored toward those over age 55. Is someone or the state preparing a document?

Mr. Sanchez stated that a number of foundations are doing write-ups. Secretary Sebelius has spoken about doing some type of outreach campaign to educate the public with all the provisions. Because it is a very lengthy bill, some things are crystal clear in the language and other things are not. The Health and Human Services Secretary shall release rules and regulations in the near future and the CMS is feeling the stress of having to try and give clear guidance of direction of all the provisions – making this a challenge.

Dr. Maria Tupas asked that with this new health care reform, is there any change for children above the Federal Poverty Level that are uninsured and above 250% and could not get private insurance? What are the changes for these individuals in this population?

Mr. Sanchez stated that those children will be obligated to buy into the insurance exchange by 2014, and rates are available for those families. And those who are below 400% will qualify for a tax credit or a subsidy payment. They can no longer use health status to keep people out.

Dr. Takashi asked if this now in place the governor or can the state no longer propose going down from 250% to 200% (FPL) coverage?

Mr. Sanchez answered that based on the MOE requirements the idea of change eligibility rules if a state proceeded with that, they would be profiting all their Medicaid and CHIP funding, and that would be a change of eligibility rules.

For more information about this report, please follow the link:
http://www.mrmib.ca.gov/MRMIB/agenda042110.html Insurance Rules

State Budget Update

A letter from MRMIB's Executive Director, Lesley Cummings, to Kris Perry with the California Children's & Families Commission, is asking them to continue to fund children from 0 to 5 in the Healthy Families Program. This last year, MRMIB received $81 million to support the current population. MRMIB is asking them to continue that in the next budget year. On the other side is a table based on the Governor's original budget proposal that was released in January 2010, and tells what actions have been taken by the legislative budget committee. The first action is to reduce eligibility in Healthy Families from 250% to 200%, which was rejected by both legislative budget committees. The idea of increasing subscriber premiums for only category B because they would have eliminated category C based on the first proposal. No action has been taken by the Senate Committee as the Assembly Budget Committee rejected it. The third proposal was the elimination of vision coverage as vision coverage for the CHIP program is not a mandatory benefit. So far, it has been rejected by the Assembly and the Senate has not taken any action. Another thing about the governor's budget proposal is it had a step or a trigger mechanism. One of the things the Governor was talking about was going to seek additional funding from the federal government. And the numbers of the states were seeking about $6.9 billion in extra money. If this was to come to pass, he had some extra cuts and the first one was to eliminate the Healthy Families Program. This has been rejected by both Legislative committees. The assembly budget committee rejected the idea of eliminating the AIM Program and no action has taken place by the Senate committee. There has been talk about eliminating the funding for the high-risk pool. No action has been taken by the Senate and the Assembly is holding this topic open.

Similar to what Dr. Wada pointed out was one of the provisions of the state to participate in the implementation of the federal temporary high-risk pool. This is what we would have to continue on spending as the same as what we spent last year. Also we are expecting the governor's May revise budget proposal which will be coming out Friday, May 14, 2010. MRMIB is waiting to see what is going to be proposed.

To view this report, please click on the link here:
http://www.mrmib.ca.gov/MRMIB/agenda042110.htmlState Budget Update

State Legislation
This handout includes a list of updates to current bills that are of interest to MRMIB. Those with asterisks are new since the last meeting. AB 1595 is the bill that would expand Medi-Cal eligibility to 133% of the FPL for adults and children, beginning January 1, 2014. AB 1602 is a spot bill that would implement the federal health care reform legislation. AB 1887 is a bill that would allow the Board to express authority to apply for federal funds. SB 227 (Alquist Bill) would expand coverage for medically uninsurable and implement a proposal that the Board has been supportive in the past which is an individual market insurance provider. It is part of the risk pool pay or play mechanism.

On page 2 is SB 900 a spot bill to implement the California insurance exchange. SB 1063 is a bill by Senator Cox that wants to raise the annual co-pay maximum in Healthy Families to $250 to $300. This would delete the provision that requires us to keep our co-payments aligned with CalPERS, which is the benchmark of our program. SB 1431

allows the County Children Health Initiative Programs. We have three counties that draw federal funds for federally eligible children in their county. They want to increase their eligibility from 300% to 400 % of poverty level.

Dr. Wada asked whether there was anything in Health Care Reform regarding raising premiums.

Mr. Sanchez stated that it is the CHIP regulations that do not allow combinations of the co-payments and the premiums to be more than 5% of families' income. The MOE provisions for the federal health care reform law were built off of to be identical to ARRA provisions, the economy stimulus package. And in that bill, CMS interrupted the idea of raising premiums in the Medicaid program as to violate eligibility rules because this is almost like a barrier to eligibility to the program by raising cost.

To view this report, please click on the link here:
http://www.mrmib.ca.gov/MRMIB/agenda042110.html. Regular Session

Premium Discount Project Update
Ms. Rouillard addressed Agenda Item 7a: the premium discount project. During the last HFP Advisory Panel Meeting, there was a discussion regarding MRMIB's interest in changing the formula for designating community provider plans, which is the plan in a particular county that has the most traditional and safety net providers. This is the plan that has the most traditional and safety net providers in its network. This has been described in the past as a complicated process that is based on data that is not reliable. It is causing a lot of difficulties not only for MRMIB staff; but also for the plans and having to justify why MRMIB has these contracts. The Board and the staff have been incorporating quality performance into the designation of who gets the CPP designation. The benefit for the plan is if the plan for CPP designation are the premiums charged to that plan are less per child per month than the other plans; therefore, plans that are in CPPT tend to get high volume of participation .

California Health Care Foundation hires consultants to help MRMIB conduct a study on how incorporating quality into the CPP designation. They spoke to the health plans, every one on the Advisory Panel, and other stakeholder groups with medical managed care staff. Their medical and managed auto assignment process incorporates quality as well as some aspect of traditional safety net provider participation. With these discussions, it became clearer that the plans were CPP. The Panel was strongly in favor of it as well as the Board. The local plans which are county specific or maybe one or two counties did not feel that is fair to compare county-based performance data with statewide plan data. The big plans such as Blue Cross, Blue Shield, Kaiser, and Health Net all report statewide data. They do not report to each county. There was a lot of concern about fairness and the staff purposed to have plans report by geographic region which made some of the major plans to report by three or four, and five by region. This got too costly and the budget year will be unable to get rate increases and with freezing and reducing rates. MRMIB is back to square one about what to do regarding the CPP process. MRMIB would like to learn more about Medi-Cal Managed Care and what goes into the algorithm. We need to figure out a better way to develop the provider list that we send to the plans because the list MRMIB gets from Medi-Cal

and Health Care Services are not complete - particularly for the counties that have Medical Managed Care. MRMIB also needs to figure out a way to address quality issue of the comparison of plans and of quality performance in a way that is more equal.

On the positive side, MRMIB expects to be collecting counter data from our plans sometime in the next year which we can use in some way. At least for the next foreseeable future (in the next couple of years) we are stuck with the process we have now. Because, any changes to the process would be statutory change, and what we have now, is not a good formula for what the calculation might look like.

Oral Health Improvement Project

Ms. Rouillard spoke about the final version of the 2008/2009 Dental Quality Report. She stated that MRMIB presented to the Board in November about this topic. Several plans used their data to get audited until they realized there was some problem with the mythology that they used to calculate their data. So the Board allowed the plans to resubmit their data. Western Dental and Access Dental were on the bottom of the scale. The capacitated plans performed much more clearly on all of the dental quality measures than the PPO plans. California health care foundation has agreed to give some funds to MRMIB to complete a dental quality improvement project. MRMIB is in the final negotiation of a contract with an organization that will help us in the following ways: MRMIB will establish dental advisory leadership groups with key national and state dental champions to service on the dental advisory groups and develop a blue print for quality improvement activities for dental care. A small group will be planning consolations with state and national oral health experts. An oral and quality improvement work group will emerge, which will include MRMIB's dental plans. Dental experts and MRMIB staff to help set program priorities and improvement targets will develop a 12-month dental improvement project in health programs starting June 1, 2010. MRMIB will create a state oral health schedule with healthy families, and a three dental action plan. It is unknown who the contractor will be at this point, but this topic will be presented to the Board at the May 27, 2010 meeting.

Dr. Tupas asked if there is a reason as to why capitated dental plan did not open up.

Ms. Rouillard answered that she does not know. But this is a part of what this group is looking into. There are some of the comments that some of the plans have made are hard to get the data from the dentist from a capacitated environment. We have heard problems from the access subscribers that they cannot find dentists to go to or there are not enough dentist available.

Mr. Sanchez stated that the new requirement for the capitated plans for the first two years of enrollment really does not apply to rural areas because the only choice that MRMIB has is a service model, which about 62% for the new enrollees are subject to. If it is a preventive visit, there are no associated co-pays.

Quality Strategy and EQRO Solicitation

Ms. Rouillard stated that when CHIPRA was signed into law, one of the provisions requires CHIP programs to conform along with Medicaid managed Care Standards. One of those provisions is quality assurance standard which has two components: The

first is for the Healthy Families Program to develop a quality strategy that addresses situations such as access to care standards, other measures of care and service related quality which, other services related to care standards, monitoring procedures. The second requires the State to contract with External Quality Review Organization (EQRO). In order to comply with this provision, MRMIB received a grant for the David and Lucille Packard Foundation which allowed the department to hire a consultant. MRMIB put out solicitations for these proposals that are now in the process of being reviewed. Five originations have submitted proposals to be the consultant and to help with these two activities. MRMIB expects to take a recommendation at the next May 27th Board meeting. The time frame for this would be over a 12-month period from June 2010 and it would go through June 2011.

Ms. Rouillard stated that in the packets, there is a power point presentation titled: "Healthy Families Benefit Review Preliminary Results." Several Board Members wanted MRMIB to look at the benefit structure of Healthy Families to identify opportunities for the program to change benefits or reduce benefits. The California Health Care Foundation funded a consultant, Deborah Kelch, who used to be the chief consultant for the Assembly Health Committee to take on this research project. She along with Mercer, another consulting firm, looked at different ways the public county programs might be structured in order to generate a program cost. On page one of the slides, the scope of the project was to develop a framework for review of benefit options, to identify options for cost-savings consistent with federal CHIP law, look at other state benefits, including "Secretary-approved" plans, and work with Mercer to complete an actuarial analysis of selected benefit designs. At the March meeting, the Board directed them to look at potential savings of different designs. One being the benchmark equivalent with the minimum benefits required under federal law. This is something that the states could come up with a benefit package that the secretary of health and human services would approve of.

The health associates of Mercer are going to look at benefit plans and Wyoming has one. In limiting the number of hospital days or office visits per year, the extent benefit limits have been approved in other state CHIP programs. Mental health and substance abuse benefits, which many states have had including California, are going to have to be eliminated due to federal parity law. Other options that Mercer looked at with potential savings from pharmacy based on review on what health plans currently do around pharmacy management and opportunities for cost sharing to subscriber increase subscriber co-pays under the federal 5% limit. There is a federal requirement that families cannot pay more than 5% of their income on a combination of premiums, and co-pays.

Mercer conducted analysis minimum benchmark equivalence plans for Healthy Families. There is an implementation of an annual benefit maximum of Healthy Families coverage, a cost- sharing options available under the CHIP 5% of income threshold, a potential cost savings related to prescription services. Mercer looked at how the costs of the service utilizing break downs currently. Inpatient care is less than 10% of the cost where you expect to see it in physician office visits and outpatient facilities. Together those two represent 75% of the program costs.

Data sources that Mercer used are discussed and there is no Healthy Families specific encounter data. Mercer did use the rate development templates that the plans submit every year to indicate what their costs are to the Healthy Families population. It is difficult to draw many conclusions from the data. Some plans are more specific to Healthy Families and other plans can encompass their entire population, and it is not that comparable from plan to plan. They did have some access to some Medi-Cal data. Since Medi-Cal data represents populations with lower income levels, the Healthy Families Program commercial data represents populations with higher income levels than HFP, we would expect HFP experience to fall somewhere in the middle.

All the federally required services that CHIP programs would have to cover are discussed in this handout as well. No changes can be made. The benchmark coverage used for comparison for prescription drugs, metal health services vision services or hearing services, then the benchmark plan must have an actuarial value of at least 75% for each of these services.

In the handout, a chart shows the potential cost savings if MRMIB was to eliminate the benefits in Healthy Families that are not required under federal law. Home Health, DME, Physical & Occupational therapy, Speech Therapy is a 1.1% capitation, which, results in a 3.9 million general fund savings.

Also, a chart shows the annual or lifetime benefit maximum limits that are prohibited as well as “unreasonable annual limits.” As far as the research that was done, they only found one CHIP program in Wyoming that has a $200,000 annual benefit max. If MRMIB had an annual benefit limit of $200,000 (if the savings were 0%-2%) then this is roughly $7.0 Million in General Fund Savings. Alternative benefit designs were also looked at, such as dollar utilization limits. There is also some benefit design or limitation would meet the limitations under health care reform.

Another chart is shown on page 18 about how MRMIB demonstrated to CMS the benefit structure and the way it maintains Healthy Families Program families far below the 5% threshold. There is a $250.00 co-pay maximum so no family pays more than $250.00 in co-pays. Category B enrollees right now have to consider the premiums that they pay and the maximum co-pays that they pay a family with children would be spending 3.21% of their income on a combination of premiums and co-pays. For families in category C (which is the 200% to 250% group), it would be a little of 3%. On page 20, the first chart for category B enrollees for 150%-200% federal poverty families and under the Governor’s proposal, MRMIB will be looking at 4.7% of family income being paid for premiums and co-pays and in category C. This is getting close to that 5% mark. This is a concern for MRMIB because CMS has indicated that families need to be made aware of when their limits are and when they are getting close to it. There is room in the structure of the program to raise co-pays and premiums.

On page 22 Mercer projects that this particular change in co-pays could potentially be raised to a $10 to $15 and this could result in a gross savings of 4.1% of total medical HFP capitation payments and in almost $9 million in state fund savings.

Pharmacy costs was discussed and viewed six of the largest healthy family plans about what they where doing to managed their pharmacy benefits within a plan cost and are about 9.6% of the total HFP expenditures. In summary, on page 26, the benefits changes studied and analyzed the following have savings potential. Minimum benefit as benchmark equivalent, annual benefit limit of $200,000 Increases in subscriber cost sharing.

Informational HFP Reports
To access these reports, please click on the links below the agenda item.

Enrollment and Single Point of Entry Report
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_012110/Agenda_Item_9a._HFP_Enrollment_Report.pdf

Administrative Vendor Performance Report
http://www.mrmib.ca.gov/MRMIB/agenda042110.htmlAdministrative Vendor Performance Report

Retention Reports
http://www.mrmib.ca.gov/MRMIB/agenda042110/ Retention Reports

2009 Open Enrollment Report
http://www.mrmib.ca.gov/MRMIB/agenda042110.html 209 Open Enrollment Report

Final 2008 Dental Quality Report
http://www.mrmib.ca.gov/MRMIB/agenda042110.htmlFinal 2008 Dental Quality Report

Regulations Modifying Mental Health Benefits, Clarifying Plan Responsibilities for Children with Sever Emotional Disturbance and California Children's Services Eligible Conditions, and Modifying the Definition of Benefit Year
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_042110/Agenda_Item_7.f_Emergency_Regulations_ER-1-10.pdf

Mr. Campana asked if there were any more comments or questions. There being none, he reminds the next panel that the next meeting is Tuesday, August 10, 2010 and adjourns the meeting.